AN EVALUATION OF ASPECTS OF GROW, A SELF-HELP ORGANIZATION

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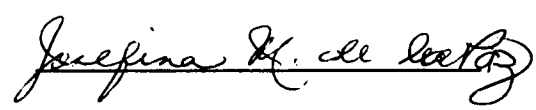
I declare that this thesis, contains no material which has been accepted for the award of any other higher degree on graduate diploma in any university and to the best of my knowledge and belief contains no material previously published or written by another person, except when due reference is made in the text of the thesis.



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ABSTRACT

The changing perspectives in mental health care have paved the way for the emergence and proliferation of self-help groups (SHGs) in the delivery of mental health care. Studies of the efficacy of such groups have been limited and have led to conflicting results. The present preliminary investigation focused upon Grow, a prominent self-help organization. The project aimed to describe the demographic, personal and psychiatric characteristics of Grow attenders, and to investigate possible changes in symptomatology and social network as a function of time and attendance.

The subjects were 62 Grow attenders who were representative of the state population of Grow members. The General Health Questionnaire (Goldberg, 1967), the Social Environment Questionnaire (Winefield, 1979), the Personality and Social Network Adjustment Scale (Clark, 1968) and a number of visual analogue scales related to issues such as perceived efficacy of Grow were administered weekly over a six week period.

General findings indicated Grow attenders to be predominantly female, 40 to 60 years old, married and from the middle occupational status group. Attendance at Grow tended to be irregular and the most common reason for attendance was to seek help for emotional problems. From a community mental health perspective most had sought help before joining Grow and many were still receiving psychiatric assistance. Previous and current help received from outside Grow tended to be viewed as inadequate. Over the period of study there was an improvement in psychological/psychiatric adjustment of Grow members but no significant change in social support networks. Only those who attended Grow regularly evidenced an improvement in social support. The need for caution when discussing causality was stressed.

A number of methodological and logistical problems were identified and more complex evaluation research designs were described for future consideration.

I. INTRODUCTION TO THE INVESTIGATION

1.1 Overview

1.2 Aims

1.1 Overview

The goal of the treatment of the mentally disturbed may be stated as the preparation of patients to function adequately in the community (Bachrach, 1978; Leigh, 1968).

From the admission of a patient to a hospital or clinic, through assessment and treatment to discharge and aftercare, this one goal is adhered to. However, as a result of the growing complexity of the mental health system and demands upon it, there are reported problems frustrating the achievement of this goal: doubt concerning the efficacy of treatment, service delivery, accessibility, availability of services, professional capabilities and accountability, and financial difficulties (Coleman & Broen 1972; Kaswan, 1979; Rappaport, 1977; Rosenhan, 1973). The result has often been that patients have been discharged from psychiatric hospitals inadequately prepared for community living (Anthony, Buell, Sharratt & Althoff, 1972; Carpenter, 1978; Ellsworth, 1978; Heller & Monahan, 1977; Lamb, 1979; Salem, 1984; Torrey, 1987; Ullman & Krasner, 1975).

One response to such inadequacy has been the establishment of a variety of post-hospital rehabilitation programmes. Some of these have been residential often following half-way house pattern, as exemplified by the Richmond Fellowship houses; some have been employment and activity oriented programmes, for example the Psychiatric Rehabilitation Association; and some have been concerned to establish a self-help social support system among peers, for example Recovery Incorporated and Grow.

The origin of these programmes is also diverse, but an increasing number have been established by former mental patients and have evolved from a long history of self and mutual help organisations.

The self-help movement in mental health care can be traced from the middle ages through to the industrial revolution when loosely organized mutual-aid groups were formed to help cope with the stresses of industrialisation (Katz, Eugene & Bender, 1976). Members grouped together with an emphasis on self-protection and to a lesser degree, personal change. Self-help groups grew in number during the stressful times of the great depression of the 1930's and World War II (Brenner, 1973; Tracy & Gussow, 1976). Specific purpose groups were formed to help victims of the war cope with physical and mental problems and although philosophies varied from need to need and from group to group, the one common trend was the linking of those who faced similar difficulties to share discovered solutions and to offer understanding and accepting support (Back & Taylor, 1976; Hurvitz, 1976; Katz et al., 1976).

The community based origins and pragmatic nature of self-help groups, have meant that most have not operated from a conventional or even recognisable theoretical base. Consequently, although participants and supporters have been enthusiastic, there have been few studies attempting to evaluate the claimed effective use of these programmes (Hirsch, 1980; Knight, Wollert, Levy, France & Padgett, 1980; Levy 1976, 1978; Lieberman & Bond, 1976; Lieberman & Gourash, 1979; Wollert, Levy & Knight, 1982). It is to this end, with one such organization, that the present preliminary study is addressed.

Grow, then called Recovery, was founded in 1957 by a group of former mental patients. Although it has become a large and widespread organisation, it has retained its non-professional character. The organisation's structure involves provision for the continuing self-evaluation and subsequent modification of programme material. However, changes result only from the pooling of the experience of Grow leaders and there has not been any independent empirical evaluation of any aspect of Grow's functioning or effectiveness.

With the spread of Grow's activity throughout Australia and overseas, it is increasingly important that such evaluation be undertaken to establish what aspects, if any, of the Grow programme are of particular use; to assess how effective or otherwise it is relative to the more traditional mental health service delivery programmes; to identify if it is of particular use to specific groups of patients; to evaluate if it is effective as a preventive programme, and if so, among what population. Such an evaluation could be expected to be of value to Grow in that aspects of its programme might be modified or enhanced. Professional helpers and others directly involved in the care of the mentally ill might also be helped by such an evaluation to assess appropriate referrals to Grow.

An additional consideration underlying the proposed investigation relates to issues such as cost effectiveness and public accountability. Grow has developed into an extensive organisation with more than 300 groups in Australia alone, with a budget from the commonwealth and state governments in excess of $1.5 million per annum (1985-1986). Any information relative to its effectiveness would be of immediate relevance to such funding bodies.

Furthermore, Grow claims to provide a social support network for a large number of isolated and distressed individuals, and it would be useful to have information concerning effectiveness or otherwise of such networks in contributing to rehabilitation from, and prevention of, mental illness. A second catalyst to the consideration of this issue comes from the considerable research attention currently being paid to the role of social support in the maintenance of mental health. Propositions generated to date, include the possibility that social support provides a buffer against adversity, and that social support may play a therapeutic role following the onset of particular disorders (Henderson, 1984).

1.2 General Aims

In the light of these considerations, the general aims of this preliminary investigation are as follows:

1. To describe the demographic, personal and social characteristics of Grow attenders.

2. To describe the Grow attenders' psychiatric/psychological adjustment, social support and perceived efficacy of Grow.

3. To investigate any possible effects of attendance at Grow meetings on members' current psychiatric symptomatology and psychological adjustment.

4. To investigate possible changes in members' social support systems and to consider the extent to which these changes may relate to Grow attendance.

II. REVIEW OF THE LITERATURE

2.1 The Traditional Mental Health System

In the history of the treatment of mental disorders, there have been three significant movements toward change and improvement (Heller & Monahan, 1977; Hobbs, 1964; Korchin, 1976). Each movement presented its own conceptualization of mental illness upon which the approaches and techniques of the mental health services were generally based.

The first movement described the mentally disturbed as physically ill and in need of humane attention. Pioneered by Pinel, the movement drew attention to the fact that the mentally ill were neglected by their families, friends, professionals and the society in general. Therefore, central to Pinel's thesis was a move towards increasing humane concern for, and management of, the mentally disturbed.

The second movement, pioneered by Freud, claimed that there was a psychological basis to mental disturbance and therefore it was amenable to psychological management. The introduction of the concept of psychic determinism led to the preoccupation with the intra-psychic life of man (Hobbs, 1964). As a consequence of this conceptualization the treatment of the mentally disturbed was pursued purely within a professional context and was usually undertaken within a hospital or clinic setting.

While the psychotherapeutic approaches broadened and became more complex, they attracted harsh criticism from Eysenck (1952) who argued that they were time consuming, costly and uncertain in terms of outcome (Gottesfeld, 1979; Guerney, 1969; Heller & Monahan, 1977). Although Eysenck's initial findings were described by Bergin (1971) as ambiguous and pessimistic, and while arguments continue concerning the complex questions raised by Eysenck (Saccuzzo & Kaplan, 1984), the U.S.

Presidential Commission on Mental Health in 1978 reported a general consensus of findings many of which supported the views of Eysenck. The report contained criticisms including the following: that traditional mental health treatment approaches were lengthy and time consuming; that the techniques employed were based on the medical model of disease which provided ineffective and expensive treatment for much emotional and psychological disturbance; that reliance on purely professional skills led to manpower shortages; that the costly approaches made the mental health services available only to a selected often privileged few; and that the medical model of mental illness gave minimal consideration to other external influences which may be casual factors in the development and maintenance of mental health problems. As a result of such criticisms of traditional mental health philosophy and practise, an alternative approach to mental health has emerged (Bender, 1976; Gottesfeld, 1979; Guerney, 1969; Heller & Monahan, 1977; Korchin, 1976; Rapoport, 1960).

2.2 Emergence of Community Based Treatment Programmes

On the basis of the documented inadequacies of the first and second mental health movements, many commentators have concluded that it is no longer tenable to view mental disorder as either solely psychologically or biologically determined. Rather, it is argued that a symbiotic relationship exists between the person and social/environmental factors (Heller & Monahan, 1977; Krasner & Ullman, 1973). These factors and other societal problems such as those attributed by war catastrophe (Rothman, 1971), unemployment and economic instability, contributed to the shift from a purely medical model approach to a consideration of social environment and economic constraints that may exacerbate mental illness (Brofenbrenner, 1974; Goldenberg, 1971; Krasner & Ullman, 1973).

Consequently, because of the above views and factors, an approach emerged emphasizing the role of societal and community factors in the development, maintenance, treatment and prevention of mental disorders. Otherwise known as the third mental health movement, it gained in impetus in the 1960's. Within this movement attempts have been made to view mental health from a new perspective and consequently perceived new methods for dealing with individual problems (Zax & Cowen, 1976). Patients were considered as part of the family and community in general (Rothman, 1971). The goal was to equip them with skills and to develop their capabilities for community living (Heller & Monahan, 1977). Therapeutic approaches such as milieu therapy (Bender, 1971; Coleman & Broen, 1972; Martin, 1970; Rothman, 1971), family therapy, network therapy and other group therapies were employed in addition to the traditional mental health approaches (Gottesfeld, 1979). To achieve this, hospital environments were often restructured into therapeutic communities where patients were prepared for independent living outside the hospital setting. New community mental health services were created to provide immediate assistance to both the patient and the family to avoid feelings of rejection and/or alienation in the disabled. Free clinics were expanded to make services more accessible and available to all. Additional innovations included more provision for after care, half-way houses, board care homes and preventive interventions (Fenton, Tessier & Struening, 1979; Marx, Test & Stein, 1973; Mosher & Men, 1977; Polak & Kirby, 1976; Stein, Test & Marx, 1975).

The community based approach placed considerable emphasis on the prevention of mental illness (Caplan, 1974). Factors such as the different societal situations affecting mental health, how they affect the

psychological and emotional being of a person, and how people can be helped to adjust and cope with the social situations have been increasingly emphasized.

While community based treatment programmes proliferated and were enthusiastically endorsed, few were evaluated adequately or were subjected to evaluations resulting in equivocal or negative findings (Elland, 1980; Lipton, 1980; Lounsbury, Leader, Meares & Cook, 1980). In some studies, board care homes were observed to be a mere extension of an institution in the community (Lamb, 1979) and often, treatment programmes were found to be no more effective than hospital based programmes (Ellsworth, 1978). Additionally, the reported survey on the use of transitional houses, although found to be cost-effective (Carpenter, 1978), did not actually help independent functioning (Anthony et al., 1972; Carpenter, 1978; Cometa, Morrizon & Ziskoven, 1979). Most commentators would contend that the question of the efficacy or otherwise of community based programmes is far from being answered and recommendations for future evaluation strategies have been outlined (McLure, Cannon, Allen, Belton, Connor, D'Ascoti, Stone, Sullivan & McLure, 1980).

Nevertheless, the movement has continued to develop innovative approaches to a wide range of personal and societal problems employing community intervention programmes, consultation, education and attitude change, with most of these features being found in community centres. In parallel with the community based approach to public health issues, increasing emphasis was placed on the use of non professionals. (Brofenbrenner, 1974; Guerney, 1969; Korchin, 1976; Miller & Miller, 1970; Rappaport & Chinsky, 1974; Rioch, Elkes, Flint, Udansky, Newman & Silber, 1963).

2.3 Non-Professionals and Self-Help Groups

The anti-poverty campaign of 1960's, the Community Mental Health Act of 1963, the establishment of National Institute for Mental Health, and the emergence of community-based approaches to mental health broadened the scope of mental health service delivery and required a wide range of manpower skills in order to carry out its objectives. Related to this, expansion in the range and number of problems and needs delineated as requiring attention, necessitated more comprehensive mental health services.

As a result, adjunctive fields of psychiatry including clinical psychology, social work, and socio-political planning became more actively involved in mental health service. It was also apparent that with the emergence of the comprehensive public health approach, there was an increased need for the involvement of non professionals as complimentary and/or alternative resources (Blum, 1966; Goldberg, 1969; Lavoie, 1981; Rodolfa & Hungerford, 1982; Smith & Hobbs, 1966; Zax & Specter, 1974). The valuable man-power resource of the non-professionals with limited training soon became recognised (Briscoe, Hoffman & Bailey, 1975; Guerney, 1969; Korchin, 1976; Rioch et al., 1963).

The introduction of filial therapy (Andronico, Fidler, Guerney & Guerney, 1967), helper therapy principles (Reissman, 1965), the training of housewives, retired persons and college students as therapists (Cowen, Zax & Laird, 1964; Goodman, 1967; Reinherz, 1964; Rioch et al., 1963) and the use of non-professional staff in half-way houses (Lurie & Ron, 1971; Mosher & Men, 1977) exemplified the emerging role of the non-professional staff in mental health service. Mosher & Men (1977) found non-professionals generally successful in assisting both mildly and

severely disturbed patients. Further, some argued that non-professionals have considerable potential to facilitate the psychic growth and social competence of mentally disturbed persons, especially those in economically deprived circumstances (Guerney, 1969; Heller & Monahan, 1977; Korchin, 1976; Nietzel, Winnot, MacDonald & Davidson, 1977). Indeed, Durlak (1979) compared the effectiveness of professionals and para-professional helpers, concluding that the latter achieved clinical outcomes equal to or better than those obtained by the professionals. He proposed that professional training and experience in mental health were not necessary prerequisites for an effective helping person.

The increased emphasis on the creation of community based organisations for the poor in particular, represented an additional impetus to the involvement of non-professionals and self-help groups (SHGs). Included in the wide range of non-professionals were the patients themselves. They formed self-help groups bound together by common problems, by similar experiences, situations and difficulties and by their common purposes or goals in life. They had been formed largely without any professional help (Lieberman & Bond, 1978), and although in some cases specialists and professionals were involved (Borkman, 1977; Borman & Drodge, 1979; Caplan, 1974; Lavoie, 1981; Levy, 1976, 1978), the members essentially control and decide on the methods of intervention they will use (Knight et al., 1980, Lieberman & Bond, 1978). The type of assistance offered by the group is based on the natural ability of group members in helping one another (Lieberman & Bond, 1978).

SHGs proliferated after World War II and the depression of 1930's (Brenner, 1973; Katz et al., 1976) and continued to increase in number (Mowrer, 1964; Tracy and Gussow, 1976). Three of the best known were in the United States, Synanon for drug addicts, Recovery Incorporated for the

psychologically disturbed, and Alcoholics Anonymous for alcoholics. These and other types of SHGs such as Make Today Count, Encounter Groups and Gamblers Anonymous, were viewed either as complimentary or alternative services to the professional workers (Borman & Drodge, 1979; Dean, 1970-71; Glasser, 1976; Jacques & Patterson, 1974; Katz et al., 1976; Katz & Rolde, 1981; Knight et al., 1980; Levy, 1976; Rodolfa & Hungerford, 1982; Wollert, Knight & Levy, 1980; Wright, 1971).

The self-help movement has continued to develop and expand. Problems and interest groups addressed by SHGs have included not only former mental patients and alcoholics but drug addicts, gay groups (Dean, 1970-71; Stern, 1975; Van Stone & Gilbert 1972), prison inmates, parolees and deliquents (Burdman, 1974; Reissman, 1965), depressed and isolated women (Bankoff; 1979; Buck & Dabrowska, 1981; West, 1981), gamblers (Cromer, 1978), obese individuals, the disabled and those with serious chronic physical illness (Borkman, 1977; Mantell, Alexander & Kleiman, 1976; Wagonfeld & Wolowitz, 1968; Wollert et al., 1980). Family related problems such as communication problems, problems for parents of children with learning disabilities, autistic children, breakdown of the family unit, the bereaved and single parents seeking mutual support have also been managed by SHGs (Romeder, 1981).

While the methodological sophistication and adequacy of studies have varied greatly, a wide range of positive changes has been noted following SHG attendance among the following; schizophrenics (Garison, 1978; Hammer, 1981; Hatfield, 1979; Levy, 1981; Snowdown, 1980; Tolsdorff, 1976), agoraphobics (Sinnot, Jones, Scott-Fordham & Woodward, 1981), psychosomatics (Freyberger 1979), depressed and isolated women (Bankoff, 1979; Buck & Dabrowska 1981; West, 1981). Increased family stability has been reported for alcoholics, drug addicts and gay groups

(Stern, 1975, Van Stone & Gilbert, 1972). Further, there is some evidence to indicate more effective rehabilitation and lower recidivism rates for inmates, parolees and delinquents who attend SHGs (Burdman, 1974; Reissman, 1965). And finally, a more stable adjustment and improved mental health state was noted among mental patients, elderly groups, and women in consciousness raising groups following SHG attendance (Dean, 1971; Froland, Brodsky, Olson & Stewart, 1979; Lieberman & Gourash, 1979; Lieberman, Solow & Reibstein, 1979).

In discussing effective outcomes as a result of SHG attendance, a range of personal experiences, group processes and behaviour change procedures have been delineated as potentially effective ingredients of positive outcomes. Some SHG practices that were reported to be effective in behaviour change are behavioural and cognitive procedures (Hirsch, 1980; Levy, 1976) social support and reinforcement (Miller & Miller, 1970; Panyan, Boozer & Morris, 1970), listening and focusing techniques (Glaser, 1976) and modeling and directing behaviour in learning new tasks (Jacques & Patterson, 1974; Levy, 1976). Peer counselling (Gartner & Reisman, 1977; Stern, 1975; Van-Stone & Gilbert, 1972; West, 1981), self-concept enhancement (Hurvitz, 1974; Mantel et al., 1976) the use of counselling skills such as empathy, sharing and self-disclosure (Borkman, 1977; Dean, 1971; Levy, 1976; Wollert et al., 1982), use of persuasion (Jurik, 1987) and some psychodynamic group processes (Freyberger, 1979) were also reported as helpful. Finally, group structure and group climate factors including flexible and informal groups (Stern, 1975), group cohesiveness (Levy, 1976), and positive group support have been related to positive outcomes (Dean, 1971; Froland et al., 1979; Hirsch, 1980; Knight et al., 1980; Lieberman & Bond, 1976; Wollert et al., 1980).

As with the traditional professional help, SHGs and non-professional types of help are not without critics. First, they have sometimes been seen to be anti professional (Back & Taylor, 1976) even though professionals may have been involved in the group's evaluation (Knight et al., 1980; Lieberman & Bond, 1978; Wollert et al., 1980). Secondly, psychological casualties have been reported, particularly among encounter groups and SHGs devoted to consciousness raising (Lieberman & Bond, 1976; Lieberman, Yalom & Miles, 1973). Thirdly, attempts to identify and assess outcomes have been frustrated by SHGs informal and often variable nature of functioning and long range goals which often obscure immediate beneficial effects (Miller & Miller, 1970). Fourthly, lack of knowledge and exposure of non-professionals to the processes of planning and decision making tend to make SHGs inefficient at an administrative and organisational level (Briscoe et al., 1975). Fifthly, potential problems have been recognized where a helper and a person being helped have similar difficulties and where some SHGs do not embody treatment models common to therapy groups. Such situations may result in ineffective behaviour change (Guerney, 1969; Hurvitz, 1970). Finally, it has been suggested that the social and therapeutic processes utilized in SHGs may encourage dependency, enmeshing members indefinitely and merely creating an illusion that problems are being solved (Dean, 1971; Froland et al., 1979; Henry, 1978; Lavoie, 1981; Omark, 1979).

In summary, a survey of the studies on SHGs presents a situation of conflicting evidence in terms of effectiveness. One viewpoint suggests that SHGs often produce beneficial results in relation to a wide range of psychiatric/psychological problems; that group membership provides a supportive environment which facilitates recovery (Burdman, 1974; Dean, 1971; Froland et al., 1979; Knight et al., 1980; Levy, 1976; Lieberman &

Bond, 1976; Lieberman & Gourash, 1979; Wolert et al., 1982); that group cohesiveness contributes to rapid symptomatic improvement (Levy, 1976) and that socialisation within SHGs enhances self-esteem (Hirsch, 1980). The contrary viewpoint claims that SHG facilitators lack training and knowledge of accepted therapeutic techniques (Guerney, 1969; Hurvitz, 1970), utilize authoritative and forceful approaches that pose risk and danger (Dean, 1971; Henry, 1978) and develop dependency rather than rehabilitate members (Collins & Pancoast, 1976; Froland et al., 1979; Lavoie, 1981; Omark, 1979).

With the conflicting results of the outcome studies on SHGs, little can be concluded about their efficacy. It should be noted however, that despite the criticisms and methodological shortcomings, SHGs continue to increase in number (Bloom, 1984, Mowrer, 1964; Tracy & Gussow, 1976). Because of this proliferation coupled with the paucity of adequate outcome studies and claims made for their efficacy, it is argued that further empirical work on the structure, processes and efficacy of SHGs is urgently needed (Back & Taylor, 1976; Borman & Drodge, 1979; Dean, 1971; Glaser, 1976; Hermalin, 1979; Jacques & Patterson, 1974; Katz, 1978; Katz & Rolde, 1981; Knight et al., 1980).

2.4 Emergence of Self-Help Grow

The present investigation will focus on the Australian self help mental health organisation, Grow.

Initially called Recovery, Grow started as an outgrowth of the older self-help group for alcoholics, Alcoholics Anonymous (A.A.). In 1957 in Hurstville, a middle suburb of Sydney, a number of former psychiatric patients who had been discharged from hospital, attended A.A. Meetings

for the accepting companionship which was offered. Some of them were still confused and disoriented. They were unable to take up their lives and friendships which they had had before their hospitalisation and they were lonely and without help for their rehabilitation.

The A.A. meetings, though they provided friendship, did not provide a programme central to the needs of these former patients. Consequently, they started meeting each week between A.A. meetings to share information about the ways they were coping with day-to-day problems and to devise a programme of action suited to their own recovery. The first meeting was of a group of six but it was not long before more people with similar problems were attracted to attend, and the group, when it reached about 15, split into two. The relationship with A.A. was severed and the new organisation, called Recovery, became independent.

With minimal professional involvement, only in the nature of organisational advice and assistance, the movement grew rapidly and by the late 1960's there were more than 100 groups meeting in Sydney and in most other Australian states.

Among the first members of Recovery was Dr. Cornelius Keogh, a Roman Catholic priest and academic theologian before his mental illness, who became at once the scribe for the movement, recording those things that were found by members to be useful to the process of recovery and rehabilitation. He also assisted in guiding the movement to establish an organizational form which provided for continuing revision and enlargement of the programme guided by the experience of group leaders. In the mid 1970's, with some 300 groups meeting each week throughout Australia, it was apparent that many group members had never experienced diagnoseable mental illness. Many had joined the group to help themselves

cope with emotional problems or stressful events and were not as such "recovering" from a specific disorder. This led to the decision to change the name of the organisation from Recovery to Grow (Rappaport, Siedman, Toro, McFadden, Reisch, Roberts, Salem, Stein & Zimmerman, 1985).

In 1984, there were approximately 350 groups in Australia with groups established also in New Zealand, Ireland, Hawaii, Mainland U.S. and Canada. Although a Recovery group had operated briefly in Tasmania in 1965, the first Grow groups were started in 1974 and at the time of the study there were 15 groups throughout the state.

2.5 Social Support and Psychiatric Symptomatology

A central focus of the community mental health movement is the prevention of emotional disorder through social and community intervention programmes. The shift from the traditional model to social-ecological models of human maladjustment has led to increased emphasis on the interrelationship of a range of social factors and on-going behaviour.

As noted earlier, considerable research attention is now being paid to the relationship between social support and psychiatric morbidity. This research has generated a number of propositions including the possibility that inadequate social support has a direct pathogenic effect, that adequate social support provides a buffer against disturbance and that the provision of adequate support decreases established symptomatology (Henderson, 1984).

It is apparent from recent reviews that the nature of the relationship between social support and psychiatric morbidity is far from understood (Henderson, 1984; Monroe, 1983). While cross sectional studies have often reported a positive relationship between low levels of social support and the presence of psychiatric symptoms, longitudinal studies have presented conflicting results. Blazer (1983) observed a relationship between late onset depression and social support and Hart and Williams (1987, 1988) noted a relationship between the adequacy of social support and on-going suicidal ideation in some classes of suicide attempters. Henderson and Moran (1983), on the other hand, could find no relationship between social support measures and the onset and remission of neurotic symptoms. In an overview of the social support literature, Henderson (1984) concluded that social support could not be shown to contribute to the onset of psychiatric disorder, but it may have important effects on the course of disorders.

The significance of the concept of social support in relation to the present investigation is underscrored by reviews of studies concerning the efficacy of SHGs. These indicate that SHGs generally report the existence of a supportive social environment as being their prevailing facilitative feature. While there are considerable variations in the definition of social support and the methods employed to facilitate more adaptive networks, there is substantial consensus of opinion among SHG organizations that there is a strong relationship between the provision of appropriate social support and the alleviation of psychological distress in individuals (Froland et al., 1979; Hirsch, 1980; Levy, 1976).

Specifically in relation to Grow, it is clear that the overall focus of the programme is aimed at improving the adjustment of people presenting with a wide range of personal and emotional difficulties (including major

psychiatric disorder). It is apparent from the Grow programme (1982) that a central aspect of the aim is the provision of adequate social support within an accepting group climate, as well as during day to day functioning.

Given the literature relating to social network and psychological adjustment and the emphasis placed on the provision of social support in SHG programmes, social support variables will be assessed during the present investigation.

2.6 Methodological Problems in Relation to SHG

Attempts to assess the efficacy of SHGs involve at least as many methodological problems as are encountered in traditional outcome studies of any formal therapy. Logistical, if not methodological, problems ensue from the facts that SHGs are generally loosely organized, lack formal structure, often have no clear theoretical framework and are generally voluntary organizations run by non-professionals. Many of these characteristics are present in the Grow organization.

Lieberman & Bond (1978) outlined several problem areas common to attempts to study SHGs. The first relates to the selection of outcome measures. As SHGs vary in terms of factors such as the presenting problems, demographic and personal characteristics of members, group goals and number of participants, standardized instruments used in assessing traditional psychotherapy may be inappropriate.

The second issue they raise, relates specifically to the differing values and lifestyles of SHG members. For example, attempts to measure

alterations in psychological adjustment may be confounded by SHG members' conceptualization of adjustment which may vary markedly across both persons and groups (Levy, 1979).

A third issue which poses difficulty for researchers in this area relates to the tremendous variability in time members spend in the group. Traditional outcome studies of more structured therapy can more easily set start and end points of a therapy. This therefore facilitates the establishment of a casual link between the therapeutic procedure and any behaviour change.

Fourth, SHG members are often multiple help seekers. In such instances, it is difficult, if not impossible, to assess the relative contributions that a number of sources of help may make to any behaviour change that occurs.

The final problem relates to the fact that investigators have approached the area from widely differing philosophies, perspectives and methods. This has resulted in considerable difficulties in evaluating findings across studies.

2.7 Statement of the Problem and Hypotheses

The general objective of this preliminary investigation is to describe the nature and characteristics of Grow and Grow attenders, and to assess, on a numbers of parameters, the issue of whether or not Grow serves as an effective organization for the enhancement of mental health. Consistent with this, the study will attempt to measure any changes in psychiatric and psychological adjustment, social support and perceived adequacy of Grow attenders.

Specifically, the following hypotheses will be tested:

1. That positive changes in psychiatric and psychological adjustment will be observed among Grow attenders over the period of study.

2. That positive changes in social support network will be observed among Grow attenders over time.

3. That a significant improvement in psychiatric and psychological adjustment will be apparent in Grow members who attend meetings regularly as compared to members who attend irregularly.

4. That a significant improvement in social support network will be apparent over time in regular attenders as compared to irregular Grow attenders.

III. METHOD

3.1 Subjects

3.2 Materials

3.3 Procedure

3.1 Subjects: Grow Attenders and Grow Procedure

The sample consisted of 62 Grow members from SHGs operating in Hobart, New Norfolk, Devonport, George Town, Burnie and Launceston in Tasmania. As noted, it is a voluntary organization of people with varying degrees of socio-psychological maladjustment and it is based largely on the premise that through shared learning and support, members should be able to achieve some improvement in personal adjustment.

The historical development of Grow in Australia and overseas was reviewed earlier. The Grow organization began operating in Tasmania in 1965 as Recovery Group and officially began as Grow in 1974. There were fifteen groups functioning at the time of the study. Ten groups were included in the study. The groups were selected to represent the geographical distribution of all groups throughout the state. All members who attended the meetings completed the series of questionaires. The groups varied in size from three to fifteen members. Also, because attendance was not compulsory, and new members were accepted at anytime, group size varied from week to week.

Weekly meetings are held in public venues such as schools, churches, clinics and community centres. Most meetings take place in the evenings. The Hobart City, Launceston and Burnie groups meet during the day. Meetings usually last from one and a half to two hours. They are followed by refreshments and informal discussion and socialization.

Each group elects a volunteer organizer who administers the group's activities. Members are encouraged to take turns in leading group meetings. Activities are highly structured. All Grow groups follow a uniform procedure called by the organization "The Group Method" (Grow,

1982). This printed material contains detailed instructions concerning Grow's principles, maxims and strategies for change. Community observers are accepted and are encouraged to participate.

Group activities are of two types, one section involving recitation in unison of printed material, and the other involving open discussion. The group process is divided into five sections. Each meeting opens with a routine which includes a recitation of the basic premises of the Grow programme and a commitment to principles of honesty and confidentiality. Honesty and confidentiality are the only imposed conditions for Grow attendance. The second section allows for the discussion of group problems, personal histories, recommendations of a problem solving nature and a review of member's progress. The next section involves a didactic consideration of some of the movement's written programme material and a direct discussion of commentaries on that programme. The fourth section is an extension of the second part (discussion of group problems and a consideration of possible solutions) with more time for discussion of pressing individual problems and group interaction. The final section allows for a consideration of plans for future social activities, group "housekeeping", evaluation of the meeting just held and a closing which involves a re-emphasis of their commitment to the principles of honesty and confidentiality.

A feature of the group process is the shift from encouraged subjective personal discussion in the second section, to the objective nature of the third, and return again to the subjective mode in the fourth section. This provides at each meeting the opportunity for members to practice a deliberate choice of speaking objectively. An aspect viewed as important is the discussion of the problem areas identified by individual members and the assigning of practical tasks deemed to be helpful to the

solution of the problem. All members are encouraged to offer problem solving strategies. Each individual is free to accept any which he or she considers appropriate (Grow Inc., 1981).

3.2 Materials

Front Sheet to the Questionnaires.

A short questionnaire was constructed along similar lines to that employed by Knight and his associates (Knight et al., 1980) in their research on the member's perception of the efficacy of self-help groups including Emotions Anonymous, Parents Anonymous and Make Today Count (See Appendix A). The questions were constructed to elicit information relating to the basic demographic characteristics of the members, their sources of referral, reasons for joining the group, previous sources of help and reasons why they felt Grow was effective.

An introductory paragraph was included to explain the purpose of the questionnaires. No degree of compulsion was implied. A statement of encouragement for their cooperation was included.

Attached to the front sheet were the other instruments that were employed to measure the subjects' psychiatric and psychological status, to describe their social support system, and to assess the subjects' perceived adequacy of Grow and help received from it and outside sources. Questionnaires were administered in the same order over a six week period. The front sheet was answered only on initial contact.

General Health Questionnaire (GHQ)

General Health Questionnaire (GHQ) is a self-administered psychiatric screening instrument originally developed to detect psychiatric morbidity in a general practice population (See Appendix B). It was developed by Goldberg in 1967 (Goldberg, 1972) and is reported to be suitable for either community outpatients or hospitalized psychiatric patients. The instrument covers questions about social activities, some psychological and somatic symptoms of depression and anxiety, as well as aspects of social inadequacy. The questionnaire was employed to assess the presence and intensity of psychiatric symptomatology.

This screening measure was selected as appropriate given its satisfactory psychometric properties (Goldberg, 1972), the preliminary nature of this investigation and its brevity. Given the repeated measures design, care was taken to select measures which were less likely to be intrusive.

There are four versions of the test each containing a different number of items. The relatively short 28 item version was employed in the present investigation. Each item has four options ranging from extremely positive to extremely negative responses. They are scored 0, 1, 2 and 3. A threshold score of 41/42 was employed to determine the subjects' probable level of disturbance. The lower the score the lesser the degree of psychiatric disturbance (Goldberg, 1978).

The validity of the test as a screening device in an Australian sample was studied by Tennant (Tennant, 1977). This research involved subjects who ranged from individuals with no apparent psychiatric symptomatology to severely impaired subjects. Tennant (1977) reported

adequate concurrent validity, and apart from the demonstrated utility of the test in identifying clinical from non-clinical cases, the instrument was found to be useful in indicating the severity of impairment. Its concurrent validity was found to be satisfactorily correlated with the Hopkins Symptom Checklist - HSCL - 36 (Goldberg, Rickels, Downing & Hesbacher, 1976). Further, Goldberg and his associates found it to more adequately identify individuals with psychiatric symptomatology than the HSC - 90.

Social Environment Questionnaire (SEQ)

The Social Environment Questionnaire (SEQ) was developed by Winefield (1979, 1982) and is designed to assess a number of parameters of the subjects social support network (see Appendix C). Aspects include the people with whom the subjects currently reside, the number of close friends, general acquaintances and social contacts in the past week, and the perceived adequacy of social relationships in general. This short, eight-item self-report questionnaire produces a global score (the Social Support Index - SSI) indicative of the extent and adequacy of social support.

In scoring, the names listed in each of the first four items (people they live with, people they can confide in, people that confide in them and a ranking of their closest friends) are tabulated. They are treated as their individual scores per item. In the subsequent four items which assess the subjects' perceived adequacy of their social relationships, the corresponding values specified in the questionnaire indicate their scores. The Social Support Index (SSI) is computed using the formula: (Q2 + Q4) x Q3 x Q7. The resulting score has a range of two to thirty six (2-36). The SSI value represents a summary of the subjects' available social support

network. Cut off scores of 16 and more are considered to be indicative of satisfactory social support, 12 or less being indicative of disturbed, inadequate social support.

These cut-off scores were based on Winefield's (1979, 1982) studies which compared the social support network of depressed women, men following myocardial infarction (MI) and healthy controls. The mean SSI was 12.0 for depressed women and 16.1 for the healthy controls. No differences was noted between MI patients and healthy male controls.

The psychometric properties of the scale have not as yet been fully evaluated. In a follow up of MI patients, the mean number of close supportive social contacts was 4.81 for those with satisfactory rehabilitation compared to 2.88 for those requiring rehospitalization. While the measure requires further psychometric evaluation, it was utilized in this study as it is one of the briefest measures of social support.

Adjustment Scale (Personality and Social Network Adjustment Scale - PSNAS)

Personality and Social Network Adjustment Scale (PSNAS) otherwise known as Adjustment Scale was developed by Clark (1968) (see Appendix D). It was based on a premise of social context theory (Clark, 1967; Jones, 1953) which stresses the notion that personality and social network form interrelated systems. The scale was designed to assess changes in both personality and social network, particularly within the context of therapeutic communities.

The instrument consists of nine items related to the level of adjustment in intra-personal, personal, familial and social functioning. Subjects are asked to check on a five point scale, statements that best describe their current adjustment. Particular points on each scale attract a score of 1 (See Appendix D) and the total score for all items is considered indicative of current adjustment. A score of 7.8 or more was employed to identify healthy subjects and 4.4 or less, disturbed subjects. The normative data was based on a study by Clark (1967) where a psychotic, psychoneurotic and severely personality disordered sample obtained a mean score of 4.39 compared to 7.88 for normal controls.

The PSNAS has been found to be as effective as the Cornell Index in distinguishing psychiatric patients from controls (Clark, 1968). Test-retest reliability of .70 has been reported with 62 psychotic patients over a period of between four and six weeks (Hirschfield, 1965).

As the instrument contains few items and has been reported to be useful in evaluating patient change in community based treatment programmes (Clark, 1968; Hirschfield, 1965), it was employed in the present investigation.

The Visual Analogue Scales

Six Visual Analogue Scales (VAS) were constructed to assess the subjects' perceptions relating to their contentment with Grow, the help received from it, previous and current sources of help outside Grow, the adequacy of their social relationships outside Grow and their ability to cope with their feelings (See Appendix E).

Each scale consisted of a 100 millimetre horizontal line where extreme feelings (completely contented and completely discontented) were noted on each extreme pole. The subjects were instructed to mark a point on the line which they considered best represented their current feelings. The point marked on each of the scales represented the subjects' score. The higher the score (0-100) the higher the perceived degree of discontentment or maladjustment.

The instrument had the advantages of being simple to comprehend, easy to administer, answer and score. It has been reported to be valid and reliable in finely discriminating subjects' current feelings. Clark and Spear (1964) who asked subjects to self-rate several times in rapid succession reported that marks were accurately placed where intended. Over series of spaced assessments, scores changed in response to variations in the factor being rated. The VAS procedure has also been found to be useful in the assessment of psychopathology. In an assessment of depressed patients, Zeally and Aitkeen (1969) report satisfactory correlations ($r = + .79$) with the Hamilton Depression Rating Scale and psychiatric interview ratings. Further, Goldney, (1979) reported that VAS ratings of suicidal intent correlated significantly ($r = + .57$) with scores on the validated Beck Suicidal Intent Scale. Finally, evaluated test-retest reliability using observer rather than self-ratings, noted a close correlation between the repeated ratings of individuals over several months (Hayes & Patterson, 1921).

3.3 Procedure

The initial contact with the Grow organization was made through the Grow field worker who was regarded as the Chairman of the

organization in Tasmania. The aims of the proposed investigation were outlined and questionnaires were presented for approval.

In turn, the Chairman outlined the study and the nature and form of the questionnaires to the Grow leaders and organizers. Considerable care was taken to plan the study so that it in no way altered the essential qualities of the organization - a community based, voluntary and confidential self-help organization for people with a wide range of perceived difficulties. Clearly, traditional outcome designs would not have been appropriate for this preliminary investigation. Additional care was taken to select measures which were brief, easy to complete and unlikely to intrude upon the Grow group programme. The researcher was mindful of earlier attempts to evaluate Grow which were rejected by the organization because the proposed designs may have altered the structure and functioning of the programme.

Upon gaining the group leaders' approval for the study, the data collection process began. Because each group met at different times and on different days, the start and end data collection points varied from group to group. However, each group was evaluated weekly over a six week period. At the initial stage of data collection, all groups in Hobart area and at New Norfolk had personal contact with the researcher. Due to distance and time constraints, Northern groups were contacted by the Grow Chairman or through telephone and mail.

To avoid disruption of the group programme, discussion of the study and data collection took place at the end of each meeting. Emphasis was placed on the importance of honest responses and the commitment to confidentiality was reinforced. The researcher, Grow Chairman and Grow

leaders clarified questions related to test instructions or test items. With the exception of the first meeting, questionnaires from the remaining five meetings were returned by group leaders to the State office in Hobart.

IV. RESULTS

4.1 Introduction to the Analysis

4.2 Demographic, Personal and Social Characteristics of Grow Attenders

4.3 Psychiatric/Psychological Adjustment Social Support and Perceived Efficacy of Grow

4.4 Demographic and Personal Characteristics as a Function of Psychiatric/Psychological Adjustment, Social Support and Perceived Efficacy

4.5 Psychiatric/Psychological Adjustment, Social Support and Perceived Efficacy as a Function of Attendance

4.1 Introduction to the Analysis

The data gathered were analysed in order to: first, describe the demographic, personal and social characteristics of Grow attenders; second, describe the subjects' psychiatric/psychological adjustment, social support and their perceived efficacy of Grow; third, evaluate possible relationships between the subjects' demographic and personal characteristics and their psychiatric/psychological adjustment, social support and perceived efficacy of Grow; and, fourth, to investigate possible changes in psychiatric/psychological adjustment, social support and perceived efficacy as a function of attendance.

The demographic and personal characteristics included:

1) age 2) sex 3) occupation 4) marital status 5) source of referral 6) attendance 7) reasons for joining Grow 8) reasons why Grow works 9) sought help before joining Grow 10) previous source of help 11) currently seeking help outside Grow 12) current source of help outside Grow. Responses were coded for analysis by SPSSX.

To describe the subjects' psychiatric/psychological adjustment, social support and perceived efficacy of Grow, they were classified according to their scores on each of the measures used. The General Health Questionnaire (GHQ) and Personality and Social Network Adjustment Scale (PSNAS) were administered to assess the subjects' psychiatric and psychological adjustment. The Social Environment Questionnaire (SEQ) was used to measure the subjects' social support network and the Visual Analogue Scales (VAS) were constructed to describe the subjects' perceived adequacy of Grow. For GHQ, SEQ and PSNAS measures, responses were re coded into three classifications: healthy, mild and disturbed.

Responses in the VAS were classified positive if close to the positive label and negative if close to the negative label. Percentages were computed and chi-square tests were employed in order to determine the demographic characteristics that could be related to the measures used.

To analyse the effects of attendance, subjects who completed one to three questionnaires were classified as irregular attenders while subjects who completed four to six questionnaires were classified as regular attenders. In order to evaluate any differential effects between regular and irregular attendance and to investigate changes over time, results on all measures were analysed by t-test. A .05 level of significance was used in this preliminary investigation to identify effects warranting further consideration despite the problems of multiple significance tests.

4.2 Demographic, Personal and Social Characteristics of Grow Attenders

The questionnaire constructed to extract the Grow attenders' demographic characteristics is presented in Appendix A. The subjects' demographic, personal and social characteristics are presented in Table 1.

Sex and Age

As shown in the Table, the majority of Grow attenders were female. The age ranged from 18 to 60 years, with a mean age of 42. The younger age group, that is, those under 30 years of age, was under represented relative to the middle and older age groups.

TABLE I

Demographic, Personal and Social Characteristics of Grow Attenders

		MALE		FEMALE		TOTAL	
		NO.	%	NO.	%	NO.	%
I.	**Age Group**						
	1 (18-30)	2	13	10	22	12	19
	2 (31-45)	6	38	16	35	22	36
	3 (46-60)	8	50	20	43	28	45
II.	**Sex**	16	26	46	74	62	100
III.	**Occupation**						
	Housewife	0	0	18	39	18	29
	Low Income	3	19	7	15	10	16
	Middle	9	56	13	28	22	36
	High	4	25	8	18	12	19
IV.	**Marital Status**						
	Single	3	19	9	20	12	19
	Married	8	50	23	50	31	50
	Divorced	2	13	5	11	7	11
	Separated	3	19	6	13	9	15
	Widowed	0	0	3	7	3	5
V.	**Source of Referral**						
	Doctor/Clinic	9	56	8	47	17	27
	Advertisement	2	13	8	17	10	16
	Friend	5	31	25	55	30	49
	Others	0	0	5	11	5	8
VI.	**Attendance**						
	Irregular	10	63	25	54	35	56
	Regular	6	37	21	46	27	44
	TOTAL	16	100	46	100	62	100

TABLE 1 (Cont'd)

		MALE		FEMALE		TOTAL	
		NO.	%	NO.	%	NO.	%
VII. Reasons for Joining							
For friendship		0	0	5	11	5	8
To seek help		3	19	14	30	17	27
To cope with emotional prob.		5	31	16	35	21	34
To cope with social rel. prob.		2	13	1	2	3	5
To gain personal growth		2	13	2	4	4	6
Because I feel lonely		2	13	2	4	4	6
Because I feel helpless		0	0	0	0	0	0
To help others		2	13	4	9	6	10
Other reasons		0	0	2	4	2	3
VIII. Reasons Why Grow Works							
Friendliness		7	44	10	22	17	28
People understand me		1	6	9	20	10	16
We all work together		2	13	9	20	11	17
Non-threatening techniques		5	31	12	26	17	28
Informative/Advice		1	6	4	9	5	8
Others		0	0	2	4	2	3
IX. Sought Help Before Joining Grow							
YES		13	81	39	85	52	84
NO		3	19	7	15	10	16
X. Previous Source of Help							
Psychiatrist	YES	10	63	27	59	37	60
	NO	6	37	19	41	25	40
Psychologist	YES	5	31	13	72	18	29
	NO	11	69	33	28	44	71
Social Worker	YES	3	19	12	26	15	24
	NO	13	81	34	74	47	76
General Practitioner	YES	7	44	20	43	27	44
	NO	9	56	26	57	35	56
Others	YES	3	19	9	20	12	19
	NO	13	81	37	80	50	81

TABLE 1 (Cont'd)

	MALE		FEMALE		TOTAL	
	NO.	%	NO.	%	NO.	%
XI. Currently Seeking Help Outside Grow						
YES	9	56	21	46	30	48
NO	7	44	25	54	32	52
XII. Current Source of Help Outside Grow						
Psychiatrist	6	67	8	38	14	47
Psychologist	1	11	4	19	5	17
Social Worker	0	0	1	5	1	3
General Practitioner	2	22	4	19	6	20
Others	0	0	4	19	4	13
TOTAL	9	100	21	100	30	100

Occupational Classification and Marital Status

The occupational classification of the sample was based on Congalton and Daniel's Occupational Status Classification (1976), with subjects being grouped as low, middle and high. Housewife was accepted as an occupational group. As indicated in Table 1 most male attenders were from the middle occupational status group, while female attenders were mostly housewives.

In terms of marital status, half of both the male and female attenders were married, 19% single, 26% divorced or separated and 5% widowed.

Grow Membership

Nearly half of the Grow attenders, mostly females, were referred by friends. Most of the males were referred by a doctor or a clinic. Others learned of Grow through advertisements or through other sources such as social workers and priests.

Attendance was generally irregular in nature. More than half of both males and females attended Grow one to three times in the six week period under investigation.

Section VII of Table 1 shows the subjects' reasons for joining Grow in terms of the frequency with which members endorsed them as their first priority. Most joined Grow primarily to cope with emotional problems. Other reasons were to seek help, to help others, to seek friendship (which was reported by females only), to gain personal growth, as a consequence of feelings of loneliness, and to cope with social relationship problems. None of the subjects reported feelings of helplessness as their primary reason for joining Grow.

The reasons most frequently endorsed for Grow's perceived efficacy were that Grow works because of its friendly atmosphere and the use of non-threatening techniques. The next most commonly reported reasons were "people understand me", and "we all work together". The proposition that Grow works because "it gives advice and information" was the least endorsed reason.

Eighty four percent of Grow attenders sought help before joining Grow, mostly from psychiatrists and general practitioners. Fewer had sought help from psychologists, social workers, and other sources such as

priests and community workers. Forty eight percent were currently seeking help, mostly from psychiatrists.

In summary, Grow attenders were mostly female, between 46 to 60 years old, married and from the middle occupational status group. Most were referred to Grow by a friend, were irregular attenders, joined Grow to cope with emotional problems, and believed Grow worked because of its friendly atmosphere and non-threatening techniques. Most had sought help before joining Grow, usually from a psychiatrist, and nearly half were still seeking help, predominantly from psychiatrists.

4.3 Psychiatric/Psychological Adjustment, Social Support and Perceived Efficacy of Grow

The subjects' description of psychiatric symptomatology (GHQ), social support network (SEQ), psychological adjustment (PSNAS) and perceived adequacy of Grow (VAS) was based on the scores of all the measures used.

The percentages of subjects classified as healthy, indicative of mild disturbance or major disturbance on the first three measures are shown in Table 2. Normative data for three scales indicated the cut off point considered to represent healthy adjustment. The cut off points between mild and major disturbance were made on the basis of available norms for a range of groups exhibiting varying degrees of maladjustment.

TABLE 2

Classification of the Subjects According to Scores in GHQ, SEQ and PSNAS

MEASURES	HEALTHY		MILD		DISTURBED		TOTAL (N)
GHQ	31	51%	21	34%	9	15%	61
SEQ	36	58%	2	3%	24	39%	62
PSNAS	38	61%	14	23%	10	16%	62

Fifty one percent of the Grow attenders were classified healthily adjusted (GHQ) whereas most of the remaining half were mildly disturbed, with only 15% evidencing major psychiatric disturbance. Individuals with mild disturbance have been reported to often remit in time without treatment while those with major disturbance tended to improve only if they were offered treatment (Johnstone & Goldberg, 1976).

In terms of the subjects' social support as measured by the SEQ, most Grow attenders reported adequate, healthy social support networks. A significant number (39%) evidenced disrupted and inadequate social support. These individuals reported few available close acquaintances, limited contact with such support and dissatisfaction when contact occurred.

The PSNAS results indicate that the majority of Grow attenders (61%) evidenced a satisfactory psychological adjustment in a range of life domains (intrapersonal, personal, familial and social). This figure is similar to the numbers reporting adequate social support systems on the previous measure. Mild maladjustment was evident for 23% of attenders, with 16% reporting major disturbance.

TABLE 3

Percentage of Subjects' Responses in Categories of Visual Analogue Scales

Visual Analogue Scales	Positive	Negative
VAS_2 (Grow in general)	73	27
VAS_3 (Help received from Grow)	80	20
VAS_4 (Social relations outside Grow)	63	37
VAS_5 (Ability to cope with feelings)	59	41
VAS_6 (Previous help outside Grow)	17	83
VAS_7 (Current help outside Grow)	28	72

Visual Analogue Scales measured the subjects' perception of factors including the efficacy of Grow and of present and previous help. The scales assessed the following: a) how Grow works in general, VAS_2, b) help received from Grow, VAS_3, c) social relations outside Grow VAS_4, d) ability to cope with feelings VAS_5, e) previous help outside Grow VAS_6, f) current help outside Grow VAS_7.

Most subjects' perceived as positive the following aspects: how Grow works in general, the help received from Grow, relationships outside Grow and ability to cope with feelings. A perceived dissatisfaction was shown towards the previous and current help outside Grow.

In summary, Grow attenders evidenced a range of psychological adjustment from healthy, through to mild disturbance, with only a small proportion presenting with major psychiatric disorder. While the majority

reported an adequate social support system, a substantial number showed an inadequate support system with few sources of support and few (generally unsatisfactory) social contacts. As with social support, similar numbers reported satisfactory psychological adjustment in intrapersonal, personal, familial and societal contexts.

4.4 Demographic and Personal Characteristics as a Function of Psychiatric/Psychological Adjustment, Social Support and Perceived Efficacy

The second phase of data analysis was to examine the relationships between the measures used, (GHQ, SEQ, PSNAS, and VAS) and some aspects of the subjects' demographic characteristics. In Table 2, the subjects were classified as healthy, mild and disturbed in psychiatric/psychological adjustment and social support. For further analysis only two categories, healthy and disturbed (mild and disturbed), were studied in relation to demographic variables. Results are shown in Table 4 in the form of percentages.

As indicated, approximately half of the Grow attenders reported mild or disturbed psychiatric symptomatology (GHQ). Those presenting with some degree of disturbance were mostly from the middle age group, female, single or divorced, irregular attenders, low occupational status group and often referred to Grow by friends. They considered that Grow was effective because people worked together. They tended to join Grow to seek help for emotional problems and, to a lesser extent, to seek friendship to overcome loneliness.

TABLE 4

Demographic, Personal and Social Characteristics as a Function of GHQ, SEQ, PSNAS

	GHQ		SEQ		PSNAS	
	Healthy	Dist	Healthy	Dist	Healthy	Dist
	51	49	58	42	61	39
Age Group						
1 Young	21	18	17	21	13	29
2 Middle	25	42	33	37	36	29
3 Old	54	39	50	42	47	42
Sex						
Male	29	24	21	29	26	25
Female	71	76	79	71	74	75
Attendance						
Regular	54	36	58	34	50	33
Irregular	46	64	42	66	50	67
Marital Status						
Single	14	24	8	26	13	29
Married	64	39	79	32	66	25
Divorced	0	18	4	16	5	24
Separated	14	15	8	18	13	17
Widow	7	3	0	8	3	8
Occupational Group						
Housewife	25	30	29	29	32	25
Low	11	21	8	21	13	21
Middle	43	30	38	34	40	29
High	21	18	25	16	16	25

TABLE 4 (Cont'd)

	GHQ		SEQ		PSNAS	
	Healthy	Dist	Healthy	Dist	Healthy	Dist
Source of Referral						
Doctor/Clinic	25	30	21	32	24	33
Advertisement	22	12	21	13	24	4
Friend	46	49	54	45	50	46
Others	7	9	4	11	3	17
Reasons Why Grow Works						
Friendliness	29	24	25	29	32	21
Understand	14	18	17	16	16	17
Work Together	7	27	17	18	16	21
Non-Threatening	32	24	25	29	24	33
Advice/Information	11	6	8	8	8	8
Others	7	0	8	0	5	0
Reasons for Joining Grow						
Friendship	4	9	4	11	5	13
Seek Help	18	36	17	34	24	33
Cope with Emotional Prob.	36	33	42	29	34	33
Cope with Social Rel. Prob.	11	0	8	3	8	0
Seek Growth	7	6	8	5	5	8
Lonely	4	9	0	11	5	8
Helpless	0	0	0	0	0	0
Help Others	14	6	13	8	13	5
For Other Reasons	7	0	8	0	6	0

There was a non significant trend for married Grow attenders to have a more satisfactory psychiatric adjustment than single, divorced, separated and widowed (X^2 = 8.23, df = 1, p = .08).

The SEQ results identified a group with disturbed social support among Grow attenders. These included more of the following: the middle to older age group, females, single, divorced, separated and widowed individuals, irregular attenders, of lower occupational status, referred to Grow by doctor/clinic, who believed that Grow worked as a consequence of friendliness and the use of non-threatening techniques, and who joined Grow to seek help for emotional problems and feelings of loneliness.

The variables that were found to have a significant relationship with SEQ results were marital status (X^2 = 13.81, df = 1, p < .001) and current help X^2 = 5.55, df = 1, .02 > p > .01. These findings indicate that a disturbed social support characterized current help seekers and the single, divorced, separated and widowed.

PSNAS results identified some subjects as disturbed in terms of psychological adjustment. Those identified as disturbed were commonly observed to have the following demographic characteristics: either young or from the elderly age group, irregular attenders, single, divorced, separated and widowed, from the low and high occupational status groups, to be referred to Grow by a doctor or clinic, to believe Grow worked because of the use of non-threatening techniques, and to have joined Grow to seek help and friendship.

Marital status showed a significant relationship with PSNAS results (X^2 = 11.11, df = 1, p < .001). Married subjects reported a more healthy psychological adjustment than single, divorced, separated and widowed.

TABLE 5

Demographic, Personal and Social Characteristics as a Function of the Visual Analogue Scales (%)

	VAS_2		VAS_3		VAS_4		VAS_5		VAS_6		VAS_7	
	Cont	Dist	Cont	Dist	Cont	Dist	Cont	Dist	Cont	Dist	Cont	Dist
	73	27	80	20	63	37	59	41	17	83	28	72
Age Group												
Young	20	19	17	33	19	23	17	25	10	22	12	23
Middle	39	25	38	25	32	36	39	29	30	36	47	29
Old	41	56	45	42	49	41	46	46	60	42	41	48
Sex												
Male	23	38	23	42	30	18	23	29	20	28	41	20
Female	77	62	77	58	70	82	77	71	80	72	59	80
Attendance												
Regular	50	31	47	42	54	32	51	37	30	48	35	48
Irregular	50	69	53	58	46	68	49	63	70	52	65	52
Marital Status												
Single	18	25	15	42	8	36	8	33	10	22	17	21
Married	59	31	62	8	62	36	63	38	60	50	65	46
Divorced	9	13	8	17	14	5	6	17	20	8	6	11
Separated	12	25	13	25	14	18	20	8	10	16	6	18
Widow	2	6	2	8	2	5	3	4	0	4	6	5
Occupational Groups												
Housewife	32	19	32	8	33	23	34	21	40	26	29	27
Low	16	12	15	17	16	9	12	16	0	18	18	16
Middle	36	37	38	33	35	41	34	42	40	36	35	36
High	16	31	15	42	16	27	20	21	20	20	18	21

TABLE 5 (cont'd)

	VAS_2		VAS_3		VAS_4		VAS_5		VAS_6		VAS_7	
	Cont	Dist	Cont	Dist	Cont	Dist	Cont	Dist	Cont	Dist	Cont	Dist
Source of Referral												
Doctor/Clinic	25	38	26	42	27	27	20	38	10	32	53	18
Advertisement	18	12	17	8	19	14	17	16	10	18	23	14
Friend	50	38	51	33	51	41	54	38	70	42	18	59
Others	7	12	6	17	3	18	9	8	10	8	6	9
Reasons Why Grow Works												
Friendliness	30	19	28	28	30	23	26	29	20	26	17	30
Understand	16	19	17	8	13	23	14	21	10	18	18	16
Work Together	16	25	15	33	19	18	23	13	20	18	18	18
Non-Threatening	27	31	30	25	27	27	26	29	40	26	4	23
Advice/Info.	7	6	6	8	8	5	8	4	0	8	16	9
Others	4	0	4	0	3	5	3	4	0	4	0	4
Reasons for Joining Grow												
Friendship	7	6	6	8	5	9	3	13	0	8	12	5
Seek Help	30	25	28	25	24	36	23	38	10	32	17	32
Emotional Pro.	34	37	36	33	41	27	37	33	50	32	29	36
Social Rel. Pro.	2	13	4	8	3	9	6	4	10	4	12	2
Seek Growth	9	0	9	0	8	5	8	4	10	6	6	7
Lonely	2	13	2	7	3	5	3	4	10	4	12	5
Helpless	0	0	0	0	0	0	0	0	0	0	0	0
Help Others	11	6	11	8	11	9	14	4	10	10	6	11
Other Reasons	5	0	4	0	5	0	6	0	0	4	6	2

Visual Analogue Scales show most Grow attenders contented with Grow in general (VAS_2) and with the help received from it (VAS_3). The majority were satisfied with their social relationships outside Grow (VAS_4) and felt able to cope with their feelings (VAS_5). Most were dissatisfied with the previous (VAS_6) and current help (VAS_7) they received outside Grow.

Those who perceived Grow as inadequate (VAS_2) and felt discontented with help received from it (VAS_3) were predominantly male, unmarried (single, divorced, separated and widowed), irregular attenders, from the high occupational status groups, who were referred to Grow by doctor/clinic. They tended to believe that Grow worked because people worked together and they joined Grow as a consequence of loneliness and problems with social relationships. In terms of age, the older age group perceived Grow as inadequate and the younger age group felt discontented with the help received from Grow.

Those who negatively perceived their social relationships outside Grow (VAS_4) and felt unable to cope with their feelings (VAS_5) were the young single, irregular attenders, from the middle occupational status groups, who joined Grow to seek help and who believed Grow worked because members understood them. Subjects from the high occupational status group, who learned about Grow through other sources such as priests and community leaders and who joined Grow because of social relationship problems, perceived their social relationships outside Grow as inadequate. Those who were referred by a doctor or a clinic, and who joined Grow for friendship, felt unable to cope with their feelings.

Subjects who were discontented with previous help outside Grow (VAS_6) and with the current help outside Grow (VAS_7) tended to be the young, regular attenders, single and separated, who joined Grow to seek help. Other subjects who perceived previous help outside Grow as inadequate were the male, widowed, from the low occupational status group, referred by doctor or clinic, who learned about Grow through advertisements and joined Grow for friendship. An additional subject group discontented with the current help outside Grow comprised divorced females, referred to Grow by friends. They considered that Grow worked as a consequence of its friendly atmosphere and the use of non-threatening techniques and they joined Grow to cope with emotional problems.

Married subjects typically indicated positive perceptions of the help received from Grow (VAS_5 : $X^2 = 11.37$, df = 1, $p < .001$), were satisfied with their social relationships outside Grow (VAS_4 : $X^2 = 9.08$, df = 1, $p < .01$) and felt able to cope with their feelings (VAS_5 : $X^2 = 9.45$, df = 1, $p < .01$).

In summary, the demographic and personal characteristics of Grow attenders that showed some degree of relationship with most of the measures used were marital status, and attendance. The overall findings indicated a disturbed psychiatric/psychological adjustment and an inadequate social support among unmarried (single, divorced, separated and widowed) and irregular attenders. Further, they tended to perceive Grow and the help received from Grow as inadequate.

4.5 Psychiatric/Psychological Adjustment, Social Support and Perceived Efficacy as a Function of Attendance

An analysis of the overall changes over time on each of the measures used is shown in Table 6. Results related to the differences in effects of attendance on the measures used are shown in Table 7.

TABLE 6

Mean Change Over Time (From 1st to Last Session) in Adjustment and Visual Analogue Scales

	D	DF	t	SIG
GHQ	4.48	43	2.4150	*
SEQ	.31	41	.3206	NS
PSNAS	.86	41	2.3078	*
VAS_2	1.025	39	.3797	NS
VAS_3	.76	40	.2796	NS
VAS_4	6.93	40	.1244	NS
VAS_5	6.075	39	.3667	NS
VAS_6	1.88	33	.5289	NS
VAS_7	3.185	27	.6872	NS

* $p < .05$, ** $p < .02$

It is apparent from Table 6 that over the period of study, there was an improvement in the subjects' psychiatric adjustment (GHQ) and psychological adjustment (PSNAS) but no improvement in social support (SEQ). This suggested the possibility that attending Grow may have had some beneficial effects in terms of attenders' psychiatric/psychological status.

TABLE 7

Mean Change From 1st to Last Session in Relation to Attendance

	ATTENDANCE A=1-3 WKS B=4-6 WKS	N	MEAN	SD	SIG
GHQ	1-3	15	-5.68	12.91	NS
	4-6	27	-3.56	11.63	
SEQ	1-3	16	-2.0	5.53	*
	4-6	26	1.73	6.13	
PSNAS	1-3	19	.86	1.86	NS
	4-6	25	.85	2.67	
VA - 2	1-3	13	-5.76	15.06	NS
	4-6	27	4.29	17.04	
VA - 3	1-3	14	3.21	20.04	NS
	4-6	27	.52	15.2	
VA - 4	1-3	15	3.26	21.87	NS
	4-6	26	9.03	18.13	
VA - 5	1-3	13	2.3	22.43	NS
	4-6	27	7.2	17.04	
VA - 6	1-3	16	3.18	24.75	NS
	4-6	18	.72	15.54	
VA - 7	1-3	9	2.77	4.44	NS
	4-6	18	3.38	28.77	

* $p < .05$

** .02

Although social support did not improve over time, Table 7 indicates a significant improvement in social support among regular attenders as compared to irregular attenders ($t = 2.03$, $df. = 40$, $.05 > p > .02$). Contrary to SEQ results, no difference in improvement was observed in psychiatric/psychological adjustment between regular and irregular attenders.

In conclusion, a relationship was observed between healthy psychiatric state (GHQ) and healthy social support (SEQ : $X^2 = 13.49$, $df = 1$, $p < .001$) and healthy psychological adjustment. (GHQ and PSNA) $X^2 = 17.77$, $df = 1$, $p < .001$). Finally, attendance at Grow was related to an improvement in subjects' psychiatric/psychological adjustment and regular Grow attendance appeared to be related to an improvement in the adequacy of social support. However, no clear casual relationship can be implied.

V. DISCUSSION

5.1 Demographic, Psychiatric/Psychological Adjustment and Social Characteristics of Grow Attenders

5.2 Group Climate and Group Processes

5.3 Possible Effects of Grow as a Function of Time and Attendance

5.4 Methodological Issues

5.5 Implications for Future Research

Discussion

Despite the limitations of this preliminary investigation, it is proposed that some of the findings will be of value in the design and implementation of more complex and ambitious studies. This project has provided some information on the demographic characteristics of Grow attenders, their level of psychiatric and psychological adjustment, the nature of their social support systems, their motivation for attending Grow and their perceptions concerning the efficacy of Grow and alternative sources of help and possible processess operating within Grow groups. This information may have some implications for the Grow organization in particular and self-help groups in general.

5.1 Demographic, Psychiatric/Psychological Adjustment and Social Characteristics of Grow Attenders

The findings in relation to demographic characteristics of Grow attenders bear some relationship to results reported in studies of other forms of SHGs. Knight and his associates (Knight et al., 1982) reviewed a number of SHGs including Parents Anonymous, Parents Without Partners, Overeaters Anonymous and Make Today Count, noting that the majority of attenders tended to be female and married. Omark's (1979) analysis of Recovery Inc. noted similar characteristics. In terms of the age distribution of attenders, Grow's age range of 18-60 years with a mean age of 42 is consistent with that of Knight and his associates (1980) who reported a range of 16-67 with a mean age of 42. Grow attender's age range is somewhat lower than Recovery Inc. (Omark, 1979) where the mean age was 49. The later finding may reflect the higher incidence of individuals with chronic, serious psychiatric disorders in the Recovery Inc.

groups, as Omark (1979) reports that the later group tended to trap members, who attended sporadically, over a long period of time, with no improvement in psychiatric symptoms.

Most Grow attenders, like in Recovery Inc. (Omark, 1979) were from the middle occupational status group. However, the low income group which was quite prominent in Recovery Inc., and which may reflect social drift (Turner & Wagonfeld, 1967), was least represented in Grow. Female attenders were mostly housewives, a characteristic common to most SHGs (Knight et al., 1980).

Friends represent the most common primary source of referral among Grow attenders. This was so for females in particular, while males were mostly referred by psychiatrists. Grow membership is very unstable. Some have been members for years, others for a matter of months and still others are first time attenders. In terms of Grow's role as a community based mental health organization, nearly half the sample only attend meetings on an irregular basis and are multiple help seekers. However, the majority of Grow attenders who sought help before attending Grow, perceived such help as having been inadequate.

Grow attenders general psychiatric/psychological adjustment and social support network ranged from healthy through to mild and severely disturbed. Those who indicated disturbance in a variety of areas of psychological adjustment were mostly young, irregular attenders, and unmarried (single, divorced, separated and widowed). Their primary reason for joining Grow was to seek help regarding their emotional problems and they believed that Grow worked as a consequence of the friendly and non-intrusive group climate.

Those who present with minimal disorder, positive social network and satisfactory personal and social adjustment tended to be married. This finding is consistent with the literature which proposes that marriage may be related to a reduced incidence of various psychological disorders (Lester, 1987; Smith, Mercy & Conn, 1988). Those presenting with satisfactory personal and social adjustment endorsed a range of reasons related to the helpfulness of Grow. These included the friendly and supportive group climate, the use of non-intrusive helping strategies and the provision of constructive information, advice and explanation.

An analysis of member's reasons for attending Grow indicates that Grow may function as a social support facility as well as a therapeutic group. This is consistent with analyses of other SHGs (Lavoie, 1981). For example, those who attended Grow in order to cope with feelings as a result of limited social support, tended to endorse reasons such as seeking friendship and help and a desire to overcome loneliness. Those coping more effectively with their feelings, requested assistance in coping with emotional and social problems, and desired to seek personal growth and expressed a concern to help others.

5.2 Group Climate and Group Processes

Given the findings of this preliminary investigation, one could speculate that Grow could be beneficial to particular demographic groups and problem types. It is proposed that Grow must embody some on-going processes that could be central to effective behaviour change.

The Grow programme is characterized by routine, uniform and highly structured procedures. Despite the fact that the programme was developed by non-professional group members and evolved as a result of

member's experiences, it is apparent that some of the processes regularly employed in meetings share similarities in principle and practice with more accepted, often empirically - oriented therapeutic approaches. This is contrary to the claim by Hurvitz (1970) that SHGs do not embrace the treatment models and methods that characterize most psychotherapy groups.

The use of non-threatening techniques where self-disclosure, warmth acceptance and friendship characterize group interaction, were the primary reasons endorsed by Grow attenders as related to Grow's efficacy. Similar findings were reported from Alcoholics Anonymous, Parents Without Partners (Wollert et al., 1982) and women in consciousness raising groups (Lieberman & Bond, 1976). The non-threatening techniques as outlined, appear to be consistent with a range of humanistic counselling approaches which stress the role of non-directive, caring, and accepting therapist and therapeutic relationship characteristics in positive outcomes (Egan, 1985; Ivey & Simek-Downing, 1980). Further, the use of self-disclosure which is considered to be a defining characteristic of constructive Grow groups (Grow, 1981), shares some similarities in emphasis with existential approaches which view self disclosure as essential for behaviour change (Jourard, 1971).

Assigning practical tasks and following them up at subsequent meetings appears to be congruent with some behaviour modification procedures using social reinforcement and homework assignments (Bellack & Hersen, 1977), and shaping and behavioural rehearsal (Wilson & O'Leary, 1980). In Grow, tasks assigned are specific, achievable, and measurable. Members contribute insights when problems and other forms of constraint arise, and in the case of accomplished tasks, members are reinforced through applause and praise (Grow, 1981). Sinnot and his associates

(1981) reported that assigning homework practice and social contact was beneficial for the group-based management of agoraphobics. Reinforcement within the group was also found useful in increasing attendance rates (Miller & Miller, 1970) and in accomplishing tasks among obese women (Wagonfeld & Wolowitz, 1968).

The principle of mutual help is the basic tenet of Grow's problem solving approach. It states that the more maladjusted they are, the more they need help, yet to grow out of maladjustment, the more they need to become concerned for and help others (Grow, 1982). As shown in this study, Grow attenders who evidenced minimal impairment in their psychological functioning, joined Grow primarily to seek help regarding their emotional and social relationship problems and expressed a desire to help others. This shared problem solving philosophy is quite akin to Reissman's helper therapy principle (Reissman, 1965; Gartner & Reissman, 1977). In their study of SHGs like Parents Without Partners, Le Leche League and Widow to Widow, peer interaction guided by such philosophy was reported to be therapeutic. (Gartner & Reissman, 1977).

Additionally, Grow's principle of "caring and sharing community" may be comparable to social milieu therapy where members develop a sense of belonging and a sense of community. This philosophy was initially seen in practice in attempts to maximize the therapeutic potential of the social milieu of hospital wards in order to create a therapeutic community (Jones, 1953). More recently, it is apparent in group therapy programmes which aim to foster a sense of community based on a constructive social network developed through group member interactions (Jones & Bonn, 1973). To date, studies of SHGs have varied in terms of their definitions of community and social support networks. However, while Collins and Pancoast (1976) reported no success in efforts to promote supportive peer

interaction and improved adjustment among minorities and the less advantaged, there are other studies which indicate that the enhancement of social support networks within SHGs may be therapeutic for group members (Hirsch, 1980; Van Stone & Gilbert, 1972; Wollert et al., 1980; 1982).

The Grow programme places considerable emphasis upon the personal responsibility for members to exert direct control over their own feeling and behaviours. Each group meeting involves the recitation of basic convictions such as "I can compel my muscles and my limbs to act rightly in spite of my feelings" and "I will go by what I know, not how I feel, and I will strive to improve my knowledge and understanding". Throughout the programme, emphasis is placed upon the 12 steps to personal growth, summarized in the phrase "we train our wills to govern our feelings" (Grow, 1982). Such processes appear to be designed to enhance member's feeling of self-efficacy and therefore bear some relationship to Bandura's self-efficacy theory of behaviour change (Bandura, 1977). Further, the repeated rehearsal of statements of basic conviction would be consistent with Meichenbaum's self-instructional training therapy (Meichenbaum, 1977) where clients are taught to rehearse positive coping statements in order to improve overt adjustment.

Finally, Grow programme's "learning to think by reason rather than feelings and imagination" (Grow, 1982) may bear some similarities to Beck's cognitive therapy (Beck, 1976) and Ellis's Rational Emotive Therapy (Ellis, 1970). While one must be cautious in interpreting the findings of the present study as they relate to efficacy, it is proposed that any improvement in the adjustment of Grow attenders as a result of the programme may, in part, be related to a range of recognized behaviour change processes involved in a variety of types of psychotherapy.

5.3 Possible Effects of Grow as a Function of Time and Attendance

While caution is necessary in discussing the complex issue of causality, attendance at Grow is related to an improvement in psychiatric and psychological adjustment. Similar observations have been made for obese females (Wagonfeld & Wolowitz, 1968) and for male alcoholics, drug addicts and ex-convicts (Van Stone & Gilbert, 1982), where sporadic long term membership (ranging from a six months to five years) was positively associated with goal achievement. In relation to the Grow organization, larger scale studies, over an extended period of time, employing measures of a variety of psychiatric syndromes and an appropriate control group, will be necessary to provide definitive information concerning possible therapeutic effects. While the marked variations in the levels of adjustment of Grow attenders make such an investigation difficult, the preliminary findings may be viewed positive.

The nature of the relationship between attendance at Grow and social network is also likely to be exceedingly complex. In the present investigation, no improvement was observed in social support over time for the total sample. However, there was a significant difference in improvement in social support between regular and irregular attenders. Those attending Grow more frequently evidenced improvement in their social support systems. It may be that regular attenders, who have such a pattern because they are more stable, are also more able to make efficient use of the social support provided by Grow members at meetings and throughout the following week. It is tentatively proposed that Grow does

provide, for some attenders, some degree of social support which is viewed as adaptive. This would be consistent with the basic tenet and some programme sequences of the Grow organization (Grow, 1982).

As outlined, Omark's (1979) analysis of Recovery Inc. noted a tendency for the organization to trap ex-psychiatric patients who attend sporadically, over a long period, with no symptomatic improvement. A similar process has been reported in relationship to the social support aspect of Grow. It has been noted that individuals presenting primarily because of social support deficits, tend to remain in the group for long periods of time with little apparent change in their adjustment (Young, 1986). Groups containing such individuals tend to stagnate, resulting in the little reduction in psychiatric symptomatology. While this observation can not be tested in this study, it is of interest to note that only healthy individuals endorsed "coping with social relationships" as their reason for attending Grow.

Given the disparate nature of Grow members, the relationship between attendance and social support will be complexly interrelated. It is clear from recent reviews that social support systems will vary as a function of the type of disorder (Henderson, 1984, Monroe, 1983), and as noted, Grow attenders vary from being well to being severely impaired. Further, there may not be a simple relationship between satisfactory adjustment and the nature and extent of the social support network. It is conceivable that social support could be experienced as a negative event by some individuals. In studies of elderly populations, it has been observed that some individuals indicate a long term preference to have only limited social contacts (Lowenthal, 1968; Kay, Beamish & Roth, 1964).

5.4 Methodological Issues

The present investigation represents a preliminary pilot study of Grow, involving a short term longitudinal analysis and a survey methodology. Given this it was neither possible to address issues such as the complex interrelationship between specific types of psychopathology and social support networks nor to make definitive statements with regard to the efficacy or otherwise of Grow.

Being a voluntary organization, care had to be taken to select measures that were short and unlikely to intrude upon the group's activities and time. Due to this limitation it was not possible to employ a measure to identify the specific nature of any psychopathology. Further, care needs to be taken when considering the results relating to social support systems. The measure employed involved few items and it has been noted that support-disorder associations can vary as a function of the definition of social support and the measuring instrument (Monroe, 1983).

The six week data collection period must be considered marginal with regard to attempts to measure changes in terms of adjustment and social network. It was not logistically possible to in any way approach the time period that the Grow organization would deem appropriate.

While the present design could not involve a comparable control group, it nevertheless would have been useful to have included a control measure for adverse life events. Henderson (1984) notes that there is an obvious overlap between the experience of adverse life events and a loss of social support, but that this fact has been ignored in many studies into the nature of the relationship between morbidity and support.

In summary, investigations of self help groups frequently involve logistical as well as methodological problems. As discussed, such groups are loosely organized, have no clear theoretical framework and are voluntary organizations run by non-professionals. All these features are apparent in relation to the Grow organization.

5.5 Implications for Future Research

It is apparent that standard outcome research designs are limited in terms of their application to the study of Grow. Allocation of potential Grow members to treatment or control groups would violate the essential non compulsory, self-help character of the organization. It was apparent from preliminary discussions that Grow leaders would not endorse such a strategy.

Given the wide variation in the psychological and psychiatric status of Grow members and the changeable attendance patterns, there is a need to employ large scale, long term prospective designs. This need is underlined by the generally accepted interactive relationship between social support and disorder and Grow's proposition that its therapeutic efficacy in part rests upon the provision of social support. It is apparent from the literature that the nature of the relationship between support and disorder is far from understood and the support-disorder association may vary as a function of the design employed, the control variables included, and the type of disorder studied. The latter fact underscores the need for large samples when evaluating the Grow organization and highlights the complexity of the issues under evaluation. The support-disorder association as well as possible therapeutic effects of Grow were under consideration.

Issues raised in this preliminary investigation are currently being addressed employing more complex designs from evaluation research. A nation wide study of the demographic, personal and social characteristics of Grow attenders has been completed (Young & Williams, 1987). A cluster analytic study of Grow members has identified sub types of Grow attenders (Young & Williams, 1988a) and a two state investigation of group processes and the social climate of Grow groups has been undertaken (Young & Williams, 1988b). An outcome study employing a quasi-experimental design with non-equivalent control groups is in progress.

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APPENDICES

Appendix A

Front Sheet to the Questionnaires

APPENDIX A

These questions are part of a study to show how GROW works. You will see it needs your help to make it accurate. Of course it is up to you whether or not you answer the questions and there is no compulsion, BUT it would be in the interest to GROW as well as the wide mental health field if you agree to co-operate.

NO. _____ DATE: _____

I. Age: _____ Sex: _____
Occupation: _____

If unemployed, previous occupation: _____
If never employed, parents occupation: Mother: _____
Father: _____

Marital Status: _____ Single
_____ Married
_____ Separated
_____ Divorced
_____ Widow

II. How did you find out about the group?

_____ Referred from a doctor or clinic
_____ Advertisement
_____ Friend
_____ Others, please specify: _____

III. Why did you join the group? Tick the one that applied to you most. If you have more than one reason, number them in order of importance to you.

_____ to seek friendship
_____ to seek help
_____ to cope with emotional problems
_____ to cope with difficulties in relating to others
_____ to attain personal growth
_____ because I feel lonely
_____ because I feel helpless
_____ because I want to help others
_____ other reason (please specify): _____

IV. Have you tried other sources of help before joining the group?
_____ YES _____ NO

If your answer is YES, tick which source/sources of help:

_____ psychiatrist
_____ psychologist
_____ social worker
_____ general practitioner
_____ others, please specify: _____

V. Please describe reasons why you feel that GROW works for you. If you have more than one reason, number them in order of importance to you.

_____ friendliness
_____ people understand me
_____ we all work together
_____ I am helped in a way that does not put me down
_____ provision of information, advice and explanation
_____ others, please specify: _____
_____
_____

Appendix B

General Health Questionnaire (GHQ)

Please read this carefully:

We should like to know if you have had any medical complaints, and how your health has been in general, over the past week. Please answer ALL the questions on the following pages simply by underlining the answer which you think nearly applies to you. Remember that we want to know about present and recent complaints, not those you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

HAVE YOU RECENTLY:

A1	been feeling perfectly well and in good health?	Better than usual	Same as usual	Worse than usual	Much worse than usual
A2	been feeling in need of a good tonic?	Not at all	No more than usual	Rather more than usual	Much more than usual
A3	been feeling run down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much more than usual
A4	felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much more than usual
A5	been getting any pains in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
A6	been getting a feeling of tightness or pressure	Not at all	No more than usual	Rather more than usual	Much more than usual
A7	been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual

---

B1	lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
B2	had difficulty in staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much more than usual
B3	felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
B4	been getting edgy and bad-tempered?	Not at all	No more than usual	Rather more than usual	Much more than usual

B5	been getting scared or panicky for no good	Not at all	No more than usual	Rather more than usual	Much more than usual
B6	found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
B7	been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual

HAVE YOU RECENTLY:

C1	been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual
C2	been taking longer over the things you do?	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
C3	felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well
C4	been satisfied with the way you've carried out your task?	More satisfied	About the same	Less satis-fied than usual	Much less satisfied
C5	felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
C6	felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
C7	been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual

---

D1	been thinking of yourself as a worthless person.	Not at all	No more than usual	Rather more than usual	Much more than usual
D2	felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual

D3	felt that life isn't worth living?	Not at all at all	No more than usual	Rather more than usual	Much more than usual
D4	thought of the possibility that you might make away with yourself?	Definitely not	I don't think so	Has crossed my mind	Definitely have
D5	found at times you couldn't do anything because your nerves were so bad?	Not at all	No more than usual	Rather more than usual	Much more than usual
D6	found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much more than usual
D7	found that the idea of taking your own life kept coming into your mind.	Definitely not	I don't think so	Has crossed my mind	Definitely has

Appendix C

Social Environment Questionnaire (SEQ)

NO: _____ DATE: _____

1. At the moment who are the people living with you?

First Name	Age	Relationship to You

2. Which one/ones do you feel you can confide in about anything which is worrying you: _____ _____
   _____ _____

3. Which one/ones seem to feel that they can confide their problems in you? _____ _____
   _____ _____

4. Think now about the other people you know. Who would you say, are your really closest friends? (These are the people with whom you feel free to 'let down your hair' when things get you down, and whom you feel you can rely on to hear you out, be sympathetic, and do their best to encourage and help you). If you can, put them roughly in order of closeness to you. Briefly say who each one is - e.g. workmate, relative, school friend, etc.

Name	Relationship	Name	Relationship
1st _____	_____	4th _____	_____
2nd _____	_____	5th _____	_____
3rd _____	_____	6th _____	_____

5. Apart from the close friends, in general NOW, would you say that you have:
   _____ more friends and acquaintances than average (3)
   _____ about the usual number of friends and acquaintances (2)
   _____ maybe fewer than the average number of friends and acquaintances (1)
   (TICK ONE ONLY)

6. In the past week, have you usually met new people through: (TICK THE MOST IMPORTANT ONE).
   _____ work
   _____ church, sport, or hobbies
   _____ through your spouse or other members of your family

7. At present, upon meeting someone for the first time, how confident do you feel than you'll be able to make a good impression and have that person begin to like you? (TICK ONE)

_____ very confident that I can (4)
_____ fairly confident that I can (3)
_____ not very confident that I can (2)
_____ very much lack confidence that I could (1)

8. When things are going wrong, at the moment how helpful do you find it able to talk things over with somebody you feel feel close to you? (TICK ONE)

_____ always helpful (4)
_____ usually helpful (3)
_____ sometimes helpful (2)
_____ never helpful (1)

Appendix D

Personality and Social Network Adjustment Scale (PSNAS)

INSTRUCTIONS:

Please complete the following questions by putting a circle around the statement that best describes how you are getting along at present.

1. I am:

/ 1		0 /		/
never in trouble with the law		occasionally in trouble with the law		frequently in trouble with the law

2. I am:

/	1 /	/ 0	/	/
very happy	moderately happy	neither happy nor unhappy (in between)	moderately unhappy	very unhappy

3. My relations with members of my own sex are:

/	/ 1	/ 0	/	/
very satisfactory	moderately satisfactory	neither satisfactory nor unsatisfactory	moderately unsatisfactory	very unsatisfactory

4. My relations with members of the opposite sex are:

/	/ 1	/ 0	/	/
very satisfactory	moderately satisfactory	neither satisfactory nor unsatisfactory (just so-so)	moderately unsatisfactory	very unsatisfactory

5. My relations with members of my family are:

/	/ 1	/ 0	/	/
very satisfactory	moderately satisfactory	neither satisfactory nor unsatisfactory (just so-so)	moderately unsatisfactory	very unsatisfactory

6. I am:

/	/ 1	/ 0	/	/
very easy to get along with	moderately easy to get along with	neither easy hard to get along with	moderately hard to get along with	very hard to get along with

7. My mental health is:

/	/	1 /	/ 0	/
very good	moderately good	neither good nor bad	moderately bad	very bad

8. I am getting along:

/	/ 1	/ 0	/	/
very satisfactorily	moderately satisfactorily	neither satisfactorily nor unsatisfactorily	moderately unsatisfactorily	very unsatisfactorily

9. I am:

/	/ 1	/ 0	/	/
hopeful about the future	moderately hopeful about the future	neither hopeful nor pessimistic	moderately pessimistic	very pessimistic

Appendix E

Visual Analogue Scales

NO: _____ DATE: _____

I. Are you currently seeking other sources of help aside from GROW Group?

_____ YES _____ NO

If YES, please tick which one

_____ psychiatrist
_____ psychologist
_____ social worker
_____ general practitioner
_____ others, please specify _____

Please put a tick on the line indicating how you feel at the moment.

II. With respect to how GROW works for me in general, I feel

/_____/_____/

completely contented — completely discontented

III. With respect to help I receive from GROW, I feel

/_____/_____/

completely contented — completely discontented

IV. At the moment I am

/_____/_____/

happy about how I relate to other outside the group — unhappy about how I relate to other outside the group

V. At the moment I feel

/_____/_____/

completely able to cope with my feelings — completely unable to cope with my feelings

VI. With the previous help I had outside GROW, I feel it was

/_____/_____/

completely helpful — completely unhelpful

VII. With the current help I am seeking now outside GROW, I feel

/_____/_____/

completely contented — completely discontented